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ABSTRACT

There are a number of advantages to including child and family therapy services in a Health Maintenance Organization (HMO). Because the concept of the HMO is based on a holistic systems-oriented model, it can utilize short-term, structured, and strategic interventions without the burdens of autocratic forms of psychological assessment, large teaching commitments, or paperwork. Therapists can be effective in an HMO setting without worrying about the "seductiveness" of keeping patients, although the therapist must have an intrinisic sense of caring for the HMO philosophy and the consumer. Pioneering work done by mental health professionals in the HMO setting is among the most creative and exciting work occurring in therapy today. (JAC)

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CHILD AND FAMILY THERAPY IN AN HMO

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APA SYMPOSIUM ON "COMPROMISES AND CHALLENGES FOR THERAPISTS IN HMO'S"

Child and Family Therapy in an HMO by A. Lee Sandler, Ph.D.

I want to warn all of you that I am heavily biased towards the HMO model and find the compromises few and challenges reasonable. The Health Maintenance Organization model has always appealed to me on the very basic level that it offers a relatively secure and respectful haven for Ph.D.'s to practice their clinical specialties without the burden of academic politics or social agency red tape. Because the concept of the HMO is based on a holistic systems oriented model, it is compatible with my theoretical basis and consistent with my interest in utilizing short term, structured and strategic interventions. I find it to be a "clean" system aimed at the competent and effecient delivery of mental health services without the burdens of the excessive and automatic form of psychological assessment, large teaching commitments, or burdensome paperwork, that satisfy cerain systems but often do nothing to enhance direct services to patients. I have found nothing more ironic than being burdened with nine and ten page evaluations and assessments coverings hundreds of variables and then typically being stuck with treatment recommendations that offer two, three, or four alternatives at best.

Many critics of the HMO system speak of the limited number of sessions per year as a compromise. I simply have not found this to be true. The twenty session limit per year has proven to be adequate for all of the children and families I see. To be honest, I can think of none that have been terminated because they reached their twenty session limit. Of course I should add that working with children and families in a middle class population helps too. The clients tend to come in more often with symptomatic and well circumscribed difficulties and rarely present with generalized

existential issues or intractable or ingrained characterological problems. If anything, the limited number of sessions has provoked us as therapists to find creative and powerful techniques and to look at structuring the therapy itself in ways other than the traditional one hour per week. We are aided by the fact that fmaily systems have a great deal of energy and potential power for change, and through the use of structural techniques (Minuchin, 1974) strategic techniques (Haley, 1973) paradoxical techniques (Palazzoli, 1978) and metaphorical techniques (Madanes, 1981), substantial change can be brought about quite quickly. Because the HMO sees itself in positive terms as a system viewing patients within their own systems, the use of family therapy makes particular sense. In the treatment of children, we also utilize couples' groups and groups for children and adolescents which have proved to be quite complementary to individual child and family therapy. One of the most exciting things about working in the child and family field and indeed in working with all systems that have the potential to heal themselves (with proper help) is finding realistic goals for therapy and not looking for magical cures. For example, I can intervene with families and children during difficult developmental phases and see them over a period of years. There are many patients at Group Health Plan in Minneapolis for example, whom I have seen for three or four years with only five to ten visits per year.

The use of active and strategic tools has also provoked the need to look at the structure of each individual session, and I have added to the more traditional listenting, reflecting, and organizing psychotherapy hour with sessions that can range from a fifteen minute delivery of a paradoxical intervention all the way up to a two hour family of origin and extended family conference that may provoke a great deal of change and affect and not be followed with another session for one to three months. I think another aspect of working in the HMO setting that has been exciting and very supportive of my work, but also very dangerous, is the fact that the burden for change

clearly lies on the patient and if the patient resists therapy too much with therapists on the staff there is no place to go and the child and/or family does not get therapy. While the fact that therapists are on salary eliminates the need to keep people in treatment for the therapists' sake, it also demands that the therapist be caring and skilled at working with resistant patients. Unlike the vulnerabilities of the private practice model, there are no rewards for keeping patients in therapy for longer and longer periods of time. Especially in the large HMO's there is a contant source of clients and those clients are coming to you because they are in pain or at least one of the children in the family is in pain. There is no need for the therapist to be "seductive" or in any way sell the therapy to resistent clients since the therapists' income is not based on maintaining a specific case load. One can expect in a well run HMO that the clients one has in therapy are people who are motivated for change and/or are in great enough pain that the issues of therapy are not compounded with the therapists' own issues about making a living. It allows the therapist to function in a therapeutic manner and take risks that I know I have found difficult and uncomfortable taking at times in my own private practice. In addition, because the families are required to stay within the limits of the health plan staff, it is more difficult for resistant families to manipulate by "shopping" for a therapist. As I mentioned before, one danger in the system, is that while we are eliminating the need to be seductive towards patients and encouraging a decrease in risk taking as a way of keeping patients in therapy, it does not (up to this point) offer incentives for quality work. Although clearly if quality care is not offered the HMO will eventually lose patients, there are as yet few such incentives since most employees are on a yearly salary. Therefore the hiring of a quality, caring and internally-motivated therapist is critical. While most systems like to include a measure of productivity as part of their

criteria for success in the mental health model. success and change are very difficult to measure and it is therefore difficult to develop a system of incentive based on quality. I know my previous organization allowed its non M.D. therapsits to maintain a private practice on the side which I know for me has satisfied my need for incentive and to test my worth on the open market, while still allowing me to function under the secure and therapeutic support of the HMO model.

Another exciting component of working with children and families in the HMO model is the concept I would call "Treating a System Within a System". While family and couples systems are many times clearly defined within the mental health community, the larger system that impinges upon the family is not as easily identifiable. One knows that a pediatrician, an internist, a Pastor, a couples therapist, a social worker and/or a nutritionist have been with the family at one time or another, but the idea of somehow grabbing onto that network and getting all those people together is burdensome and often not practical. While clearly one can involve himself or herself with the school system to treat children with emotional and behavioral problems, I personally have not found the school to be that useful. I don't find their level of resources to be that high and I don't feel the leverage or power as available as it is in terms of working directly with the family system. The HMO provides a full system of physicians, nurses, and allied health professionals representing a spectrum of specialities. The fact that all of us are visible to each other and within the same clearly defined nerwork allows consultation and feedback about cases to proceed quite nicely. I am usually, if not always, involved with the pediatricians and primary care physicians who have involvement in the families and children with whom I work and we all share a common concern. The danger here especially for the gradually evolving HMO has been in the delineation of roles of the various

professionals.. This is a problem with which Group Health Plan still struggles because mental health services have been viewed with the usual administrative fear that they would be a runaway financial burden for an HMO, and therefore developed last. This led to an open invitation for many of the internists, pediatricians, and family medicine specialists, especially those who were so inclined, to begin doing a tremendous amount of untrained or lay counseling and "psychotherapy". We have had to work hard as we developed a full complement of mental health services to have the primary care physicians, pediatricians, and family specialists trust us enough to turn over cases immediately and now instead work as referral sources and screening services. We have accomplished this by increasing our pediatric liaison (and our consultations to the rest of the groups) and by making ourselves as visible as possible over the years in our offering of competent services. Our ability to "rescue" the pediatrician and the family specialist from difficult cases has helped us develop a reputation that has encouraged the specialists to refer children with emotional-behavior problems to us expeditiously for the help they require.

It seems to me that when working with children and their families, an understanding of systems is critical. Introduction of an identified patient or symptomatic child into our system often necessitates a hard look at both the larger family system and the more specific subsystems as well. It comes as no shock to anyone in this audience that the mental health of any one individual is directly tied to those on whom they are dependent, and that it is rare and almost diagnostic in itself to see an identified patient who doesn't also bring in other siblings or a marital diad that is in some pain (or experiencing an excessive level of stress). In these cases the ability to offer systems therapy to all of the members of the system can be critical. The scope of our organization and its philosophy of holistic health permits us to offer a variety of services and treatment fot these subsystems so that

improvement in one member is enabled and supported by those intimately involved. In this vein, we have found latency age groups to be an immense help for families and children. We have found adolescent groups to be critical, especially in low resource or deficit ridden families where the adolescents are going to emancipate with or without our help. We have experimented with couples groups and are finding parenting classes to be somewhat helpful and a less threatening mode than a family treatment intervention. The last treatment mode that I mentioned, the parenting classes, are also a part of a prophylactic mental health program. Clearly, an HMO is rewarded when its members stay healthy and the consumer benefits in a very direct way. The influences on children are so powerful, that when we can have a major effect in directing powerfully positive experiences to the children, it can be most rewarding. I certainly believe that our parenting classes and parent groups have made a difference for parents who are now able to support and aid their children through developmental crises and keep their children protected from triangulation when marital tensions and disturbances threaten to overflow their boundaries. In addition, our children and adolescent groups help to provide a training ground for the development of social skills and support for developmental growth and difficult family situations that might not be available in a less structured social milieu.

By way of example, I'd like to mention a case that is not uncommon in our child and family work which illustrates some of the compromises and challenges faced. One of my colleagues, a pediatrician, called me and told me about a young woman he was seeing, who for the purposes of this case we will call Katherine. Katherine was in the process of losing a great deal of weight, was amenorrheic, she was not yet cachectic but was approaching 25% of body weight loss, and clearly from the pediatrician's description was presenting a distorted body image, fatigue, and significantly decreased pulse rate. Since the beginning of this patient's precipitous weight loss, the pediatrician had been attempting some prophylactic work in terms of

counseling around issues of nutrition and diet. The family was quite resistant and would not come in to see the pediatrician, even as their daughter continued to lose weight. Mother would accompany Katherine and the pediatrician was at a loss in terms of how to proceed. I insisted on seeing the whole family and with the support of the rest of the mental health staff and the fact that the family would have to pay out of their own pockets to receive mental health benefits outside of the HMO, the family reluctantly agreed to come in as a group. I offered to see the family for the pediatrician and to perform a three session evaluation and at that point get back to the pediatrician with my impressions and treatment recommendations. The family which included stepfather, biological mother and two younger biological children came to see me and it was quite clear tnat not only did this child meet the major criteria for anorexia nervosa but the family was also experiencing some vague, yet significantly high level of stress. The first major resistance encountered was the tremendous pressure to hospitalize this patient. I clearly did not want to hospitalize her as hospitalization is a trauma at best and I beleive that the best intervention is the least intervention necessary to ameliorate a problem. The pressure to hospitalize came from three areas. Pressure came from the family who clearly wanted to identify this patient as problematic and therefore take the pressure off of the others to reveal painful family secrets. The family pastor who was "ten credits shy of a master's degree in counseling" felt that the young woman was "insane" and that my behavior would be unethical if I did anything other than immediately put her in the hospital. I won't go into details about the dynamics of the case, but suffice to say that it became clear to me why the family was traingulating this child and protecting family secrets. It was revealed to me that three generations of physical and sexual abuse were involved in this case and at the current time a very painful marital situation was going on in which mother

had chosen the indentified patient as her confidant in discussing how "rough it was living with her stepfather". For the most part though we were able to stick to an outpatient intervention and the indentified patient did very nicely in terms of reversing her weight loss as well as creating some distance between herself and the rest of the family thus creating an enviroment where the parents were able to get some help for their own marital problems which in turn resulted in an improved family situation. As the case proceeded, both positive and negative aspects of the treatment surfaced, some of which were directly related to the HMO setting. On the positive side, the fact that the pediatrician was a colleague of mine and the priamry care physician and that we were both working in a system that stressed an holistic orientation, made the transfer of the case and collaboration quite easy. His initial cooperation and the cooperation of the nutritionist really helped to support my strong stand with the family which incidently became more and more resistive as the evaluation progressed. We were able to make a very strong and powerful case for an attempt at outpatient treatment and the fact they were involved in our system did not allow for the resistive maneuver of attempting to shop for different therapists until they heard what they wanted to hear. Another positive aspect of our own systems approach and an example, as I see it, of creativity in treatment was that as the indentified patient became free from the burden of responsibility to save the marriage, she began to put on weight and was able to get in touch with some social and peer group issues that she had been struggling with through the involovement in an adolescent group program which we were running. Mother and father continued to work on communication skills and mother was also involved in a group for assertiveness training for women with good results. Another positive aspect is that I took risks with this family in the development of family interventions that I might not have taken if I had been seeing them in private practice (out of fear of losing the case) and I probably would have acceded to their desire

for hospitalization even though that would have been costly in more than one way, traumatic and I clearly think an inhibition to substantial treatment. One clearly negative aspect of the case is that the pediatrician who before the development of the strong mental health department had been treating emotional problems had a tendency to be overinvolved, "blew" his agreement with me after the second evaluation session and there was a nasty incident in which he panicked and put Kahterine in the hospital threatening to force feed her if she continued to lose weight. The young woman panicked and (rightly so) ran away from the hospital. The whole incident was clearly anti-therapeutic and took us quite a while to work out before we could get on with the therapy. Luckily we were able to work it through because of the family's faith in the individual health care providers and in the system itself.

If I have any negative reactions to HMO concepts, as practiced by Group Health Plan, I think it is in my disappointment in not delivering on the promise of prophylactic care and on a larger systems level, involving the interfacing of the management of the HMO and the clinical staff. Clearly the offering of prophylactic care for emotional disturbances in families should be a high priority for the HMO's. Yet translating that goal into the delivery of prophylactic care and "wellness" has not yet happened on a large scale at Group Health. Part of the problem is that as a rule children and families come in in a much more resistant position than many adults who are aware of their pain and are clearly asking for help. Many times the proccesses of triangulation and scapegoating are well under way. The symptoms and emotional illness in a child by that time are the neurotic compromise, i.e. the resistant solution, and obviously in light of their chosen solutions to psychic pain people are loathe to admit stress and difficulties in a way that could be dealt with at less human and financial

cost. I don't think this is a problem reserved simply for HMO's but I think it has more to do with the fact that most people (whether patients or administrators) tend not to want to change behavior or lifestyles until they are already in such pain that they have no choice.

The other compromise that has been negative for the last five years at Group Health Plan of Minnesota is, in my opinion, attributable to the fact that our administration is composed of lay people with no clinical training. The administration on many occasions seemed to show little sensitivity to the needs of the mental health professionals and the interfacing of mental health care with physical well being and would often make policy and administrative decisions that were anti-therapeutic. The dream of wellness while being problematic from a clinical point of view was also discouraged and sabotaged by the oraganization's administration and their rigid and prejudiced attitudes about mental health. The administration also physically isolated the mental health department from other specailties which I think created a feeling of isolation among the staff, and a feeling among the patients that somehow the mental health department was different than other departments and not part of the general system (or philosophy) of care. While the administration expanded the child and family staff to cover all the population of 190,000 members, they only expanded the adult staff to something less than half that population. In the interest of "cost effectiveness" they subcontracted out more than half of the adult work to a group in town, thereby consciously creating a cost competition, which I think has created a very significant morale problem for an already cost effecient staff in which the HMO's paitents are the biggest losers. The in-house department's pressure to produce "contact hours" in order to keep up with the 100% contact hour work done by the subcontracted group's largely part-time staff has undone much patient education as well as educational activity with non-mental health

professional staff. In addition, the division of the over sixteen population group between two different providers has significantly narrowed the population base of each provider such that certain specialized services can no longer be provided. For example, the in-house mental health department had a therapy group specifically for young adults and another for middle age women which have both been stopped because of insufficient demand from its now shrunken population base. Dividing the adult staff has also created confusion as members are now seen for a family problem in the child and adolescent section but if the shift and focus in the therapy turns to more of an adult problem or to the marital subsystem they may be transferred to the subcontracted group and be seen by an unknown and unrecommended therapist. The other related issue is, of course, that the whole HMO and the mental health department within that organization rises and falls on the reputation of the subcontracted group although it has no control over the quality of those therapists hired and the type of treatment performed.

The major fear that I have for HMO's is that in the short run they could develop policies that are not in the best interest of the consumer. Therapists might then offer less than quality and concerned care since their salaries come from the hours they work and not from how well they do with their patients. We know that the quality of care will catch up with any organization but it might not be apparent in the short run.

My conclusions clearly represent two sides of a coin, with one side being that one can be effective and therapeutic in an HMO setting without having to worry about the "seductiveness" of keeping patients. On the other side though, one has to have an intrinsic sense of caring for the HMO philosophy and the consumer. The therapists must be internally rewarded by this system for good quality care, innovations in care, and the promotion of the concept of wellness since right now one is paid simply by the amount of hours one works regardless of the quality of work. My compromises have been such problems with incentives and intrusions by clinically unsophisticated, if

not unconcerned lay administrators who have had interests and motivations different from my own. My challenges have come from the encouragement and support of creative types of therapy as well as from the possibility of using the HMO system to deal with resistance, promotion of wellness and the delivery of comprehensive and integrated care.

Changes are presently occurring in Group Health Plan's own administration. These changes at least offer the hope that the problems or comprimises I have mentioned may be eventually overcome. On the other hand, the fierce competition of HMO's in the Twin Cities and indeed the state of the economy nationwide, might just keep progress both in our organization and elsewhere, a long way off. Only time will tell but meanwhile the pioneering work being done by mental health professionals in the HMO is among the most creative and exciting work occurring in our field today.

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